SD Medicaid CMHC Health Home Outcome Measures

Goal 1: Improve the health of Medicaid Health Home recipients with chronic conditions.	Measures	Data Source	Measure Specification	How HIT will be Utilized	Core Service	Measure Steward
Clinical Outcomes	**Depression:** Percentage of CMHC-HH recipients aged 12 years through 17 years screened for clinical depression using an age appropriate standardized tool and follow-up documented.	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients aged 12 years through 17 years screened for depression in the previous 12 months **Denominator** = number of all CMHC-HH recipients aged 12 years through 17 years in the previous 12 months x 100	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Health Promotion	PQRS (Physician Quality Reporting System – Centers for Medicare & Medicaid Services)
	Depression: Percentage of CMHC-HH recipients aged 18 years and older screened for clinical depression using an age appropriate standardized tool and follow-up documented.	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients aged 18 years and older screened for depression in the previous 12 months **Denominator** = number of all CMHC-HH recipients aged 18 years and older in the previous 12 months x 100	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Health Promotion & Comprehensive Care Management	PQRS
	Substance Abuse: Percentage of CMHC-HH recipients age 12 years and older who were screened for tobacco, alcohol and other drug dependencies within the reporting period.	Recipient Electronic Health Record	**Numerator =** Number of CMHC-HH recipients age 12 years and older screened for tobacco, alcohol and other drug dependencies in the previous 12 months	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Health Promotion & Comprehensive Care Management	PQRS

			Denominator = Number of all CMHC-HH recipients aged 12 years and older in the previous 12 months x 100			
	Substance Abuse: Percentage of CMHC-HH recipients age 13 years and older (adolescents and adults) with a new episode of alcohol or other drug (AOD) dependence who received the following: ▪ Initiation of AOD treatment	Recipient Electronic Health Record	**Initiation of AOD Treatment Numerator** = Number of CMHC-HH recipients aged 13 years and older with initiation of AOD treatment through an inpatient admission, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis. **Denominator** = Recipients 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18 years and older) and a total rate. The total rate is the sum of the two denominators.	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Health Promotion & Comprehensive Care Management	NCQA (National Committee for Quality Assurance)
	Substance Abuse: Percentage of CMHC-HH recipients age 13 years and older (adolescents and adults) with a new episode of alcohol or other drug (AOD) dependence who received the following:	Recipient Electronic Health Record	**Engagement of AOD Treatment Numerator =** Initiation of AOD treatment and two or more inpatient admission, outpatient	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual	Health Promotion & Comprehensive Care Management	NCQA

	▪ Engagement of AOD treatment		visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. **Denominator** = Recipients 13 years of age and older as of December 31 of the measurement year with a new episode of AOD during the intake period, reported in two age stratifications (13-17 years, 18 years and older) and a total rate. The total rate is the sum of the two denominators.	recipient.		
	Asthma: Percentage of BH - HH recipients aged 5 through 50 years of age who were identified as having persistent asthma and were appropriately prescribed medication and remained on their medication during the measurement year. Two rates are reported. 1. % of BH - HH recipients who remained on an asthma controller medication at least 50% of the	Recipient Electronic Health Record	**Numerator** = For a given 90 day period number of CMHC-HH recipients between the ages of 5 through 50 years of age identified as having asthma and a prescription for a controller medication. **Denominator** = for a given 90 day period	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	PQRS

	treatment period. 2. % of CMHC-HH recipients who remained on an asthma controller medication @ least 75% of the treatment period.		number of CMHC-HH recipients between the age of 5 through 50 year of age identified as having asthma. **Numerator** = number of CMHC-HH recipients on medication for asthma in the past 90 days with a medication possession ratio greater than 75%. **Denominator** = number of all CMHC-HH recipients on medication for asthma in the past 90 days.			
	Diabetes: Percentage of BH - HH recipients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c less than 8.0%.	Recipient Electronic Health Record	**Numerator** = For a given 90 day period, number of CMHC-HH recipients between the age of 18 to 75 years old identified as having diabetes and a documented Hba1c in the previous 12 months for whom the most recent Hba1c level is less than 8% **Denominator** = For a given 90 day period, number of CMHC-HH recipients between the age of 18 – 75 years of age identified as having diabetes and having a documented Hba1c in the previous 12 months.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with	Comprehensive Care Management	PQRS

				treatment guidelines. Results will be submitted in flat file to the state by individual recipient.		
	Diabetes: Percentage of BH - HH recipients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients 18 – 75 years of age with diabetes whose most recent blood pressure in the previous 12 months was less than 140/90 mmHg. **Denominator** = total number of CMHC-HH recipients in the previous 12 months 18-75 years of age with diabetes.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	PQRS
	Vascular Disease: Percentage of BH - HH recipients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months and who's most recent LDL-C level was in control (less than 100	Recipient Electronic Health Record	**Numerator** = During the reporting period, number of CMHC-HH recipients age 18 years and older diagnosed with Ischemic Vascular Disease (IVD) who	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment	Comprehensive Care Management	PQRS

	mg/dL).		received at least one lipid panel profile within the last 12 months and whose recent LDL-C level was in control (less than 100mg/dl). **Denominator** = CMHC-HH recipients age 18 years and older diagnosed with Ischemic Vascular Disease (IVD) who received at least one lipid panel profile within the last 12 months.	guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.		
	Obesity: Percentage of BH - HH recipients age 18- 74 years who had an outpatient visit and whom had their BMI documented during the reporting period or the year prior to the reporting period.	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients age 18 - 74 with a documented BMI during the reporting period or the year prior to the reporting period **Denominator** = CMHC-HH recipients 18-74 years of age who had an outpatient visit.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is	Comprehensive Care Management	PQRS

				consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.		
	Obesity: Percentage of BH - HH children age 6 to 17 with a calculated BMP (Body Mass Percentile) at their most recent preventative service visit during the reporting period.	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients age 6 to 17 years during the reporting period or during the current visit documented in the medical record in the denominator with a calculated BMP. **Denominator** = CMHC-HH recipients 6 to 17 years of age who had an outpatient visit.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	PQRS
	Cancer Screening: Percentage of BH - HH women ages 50–75 who had a mammogram to screen for breast cancer.	Recipient Electronic Health Record	**Numerator** = During the reporting period, Number of CMHC-HH women ages 50-75 who had a mammogram to screen for breast cancer	The medication adherence, HEDIS indicators and meaningful use measures were developed from	Comprehensive Care Management	PQRS

			Denominator: Number of CMHC-HH women ages 50-75	treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.		
	Cancer Screening: Percentage of BH - HH recipients ages 50–75 who had appropriate screening for colorectal cancer. Appropriate exams include colonoscopy, sigmoidoscopy or fecal occult blood tests.	Recipient Electronic Health Record	**Numerator** = During the reporting period, Number of BH - HH recipients ages 50–75 who had appropriate screening for colorectal cancer. **Denominator** = Number of BH - HH members ages 50–75	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific	Health Promotion	PQRS

				individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.		
	Chronic Pain: Percentage of BH - HH recipients aged 18 years and older with documentation of a pain assessment through discussion with the BH - HH recipient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Recipient Electronic Health Record	**Numerator** = Number of BH - HH recipients aged 18 years and older with documentation of a pain assessment through discussion with the BH - HH recipient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present. **Denominator** = Number of BH - HH recipients aged 18 years and older	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	PQRS

	Hypertension: Percentage of BH - HH recipients aged 18 through 85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (< 140/90 mmHg) during the measurement year.	Recipient Electronic Health Record	**Numerator** = for a given 90 day period the number of CMHC-HH recipients between the age of 18 through 85 years old in the denominator whose most recent blood pressure is adequately controlled during the measurement year. For the recipient's BP to be controlled, both systolic and diastolic BP must be less than 140/90mmHg140/90 mmHg. **Denominator** = for a given 90 day period total number of CMHC-HH recipients between the age of 18 through 85 years old identified as having hypertension and who had at least one outpatient encounter with a diagnosis of HTN during the first six months of the measurement year.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	PQRS

	SMI Medication Management: Percentage of CMHC-HH recipients 12 years and older who were identified as having a SMI and filled their prescription for 85% of the time during the measurement period.	Recipient Electronic Health Record	**Numerator =** Number of CMHC-HH recipients 12 years and older who were identified as having a SMI and filled their prescription for 85% of the time during the measurement period. **Denominator =** Total number of CMHC-HH recipients 12 years and older who were identified as having a SMI	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	NCQA

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	SMI Co-Occurring Disorders: Percentage of CMHC-HH recipients age 12 years and older who were screened for co-occurring mental illness and substance abuse disorders within 30 days of initial intake.	Recipient Electronic Health Record	**Numerator =** The number of CMHC-HH recipients age 12 years and older who were screened for co-occurring mental illness and substance abuse disorders within 30 days of initial intake. **Denominator =** The total number of CMHC-HH recipients age 12 years and older	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	NCQA
Experience of Care	**Measure and Improve Performance:** The practice or practice designee surveys CMHC-HH recipients to assess CMHC-HH recipient/family experience and general satisfaction. The survey addresses the process for establishing treatment goals and whether the goals were set by the CMHC-HH recipient or staff.	BH Health Home satisfaction survey	**Numerator** = Number of recipient responses with an affirmative response to Adult Services Outcome Tool. **Denominator** = the total number of recipient responses to Adult Services Outcome Tool.	Results for the survey responses will be submitted in flat file to the state. Results of CMHC-HH surveys will be reported in aggregate for the entire statewide Health Home Initiative.	Health Promotion & Chronic Care Management	SDDSS – DCBH (South Dakota Department of Social Services Division of Behavioral Health)

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	Measure and Improve Performance: The practice or practice designee surveys CMHC-HH recipients to assess CMHC-HH recipient/family experience and general satisfaction. The survey addresses if the CMHC-HH recipient would continue to use this service if others were available.	BH Health Home satisfaction survey	**Numerator** = Number of recipient responses with an affirmative response to Adult Services Outcome Tool. **Denominator** = the total number of recipient responses to Adult Services Outcome Tool.	Results for the survey responses will be submitted in flat file to the state by individual. Results of CMHC-HH surveys will be reported in aggregate for the entire statewide Health Home Initiative.	Health Promotion & Chronic Care Management	SDDSS – DCBH
	Measure and Improve Performance: The practice or practice designee surveys CMHC-HH recipients to assess CMHC-HH recipient/family experience and general satisfaction. The survey addresses if the CMHC-HH recipient would recommend this service to a friend or family member.	BH Health Home satisfaction survey	**Numerator** = Number of recipient responses with an affirmative response to Adult Services Outcome Tool. **Denominator** = the total number of recipient responses to Adult Services Outcome Tool.	Results for the survey responses will be submitted in flat file to the state. Results of CMHC-HH surveys will be reported in aggregate for the entire statewide Health Home Initiative.	Health Promotion & Chronic Care Management	SDDSS – DCBH

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Quality of Care	**Measure and Improve Performance:** The practice or practice designee surveys CMHC-HH recipients to assess CMHC-HH recipient/family experience and general satisfaction. The survey addresses that the outcomes that are being experienced by the CMHC-HH recipient.	BH Health Home satisfaction survey	**Numerator** = Number of recipient responses with an affirmative response to Adult Services Outcome Tool. **Denominator** = the total number of recipient responses to Adult Services Outcome Tool.	Results for the survey responses will be submitted in flat file to the state. Results of CMHC-HH surveys will be reported in aggregate for the entire statewide Health Home Initiative.	Health Promotion & Chronic Care Management	SDDSS – DCBH
	Multiple Medications: Percentage of specified visits for BH - HH recipients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements.	Recipient Electronic Health Record	**Numerator** = CMHC-HH recipients age 18 years and older that have had a recipient visit within the reporting period and have a list of current medication in the CMHC-HH electronic health record. **Denominator** = CMHC-HH recipients aged 18 years and older that have had a visit in the reporting period.	CMHC-HH attests to the presence of medication listing within the electronic health record as a matter of best practice Attestation will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	PQRS
	Pro-Active Patient Management: The practice uses BH - HH recipient information, clinical data and	Recipient Electronic Health Record/Practice Records	CMHC-HH electronic health record or electronic care	CMHC-HH attests to the evidence of reminder systems.	Health Promotion & Chronic Care	NCQA

	evidence based guidelines to generate lists of BH - HH recipients and proactively remind BH - HH recipients and families and clinicians of services needed. The practice demonstrates that during the past year it has proactively identified and provided outreach to BH - HH recipients in need of services.		management system identifies CMHC-HH recipient visits scheduled, and reminds CMHC-HH recipients of said visits.	Attestation will be submitted in flat file to the state by individual recipient.	Management	
Goal 2: Provide cost effective, high-quality health care services for Medicaid Health Home recipients.	**Measures**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**	**Core Service**	**Measure Steward**
Experience of Care	**Measure and Improve Performance:** The practice or practice designee surveys CMHC-HH recipients to assess CMHC-HH recipient/family experience and general satisfaction. The survey must include questions related to services available at a time suitable to the recipient and services needed were available.	BH Health Home satisfaction survey	**Numerator** = Number of recipient responses with an affirmative response to Adult Services Outcome Tool questions **Denominator** = the total number of recipient responses to Adult Services Outcome Tool	Results for the survey responses will be submitted in flat file to the state. Results of CMHC-HH surveys will be reported in aggregate for the entire statewide Health Home Initiative.	Health Promotion & Chronic Care Management	SDDSS – DCBH
Clinical Outcomes	**Chronic Pain**: Percentage of BH - HH recipients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients with a primary diagnosis of low back pain who did not have an imaging study within 28 days of the diagnosis.	The medication adherence, HEDIS indicators and meaningful use measures were developed from treatment	Comprehensive Care Management	PQRS

			Denominator = Number of CMHC-HH recipients with a primary diagnosis of low back pain.	guidelines. Health Homes will utilize data analytics of the diagnostic and service information in practice's electronic health record to assess and monitor the extent to which a specific individuals' care is consistent with treatment guidelines. Results will be submitted in flat file to the state by individual recipient.		
Quality of Care	**Resource Utilization**: DSS tracks the accumulated Medicaid expenditures/ total resources expended to provide care for all Health Home BH - HH recipients by tier.	Electronic Claims Data	**Numerator** = the accumulated Medicaid expenditures (inpatient, outpatient, pharmacy, ancillary services) associated with CMHC-HH recipients by risk tier **Denominator** = total number of CMHC-HH recipients by tier.	DSS will utilize its electronic claims system to identify total costs by tier and for the total	Comprehensive Care Management	NCQA
	Resource Utilization: DSS tracks the accumulated Medicaid expenditures/resources expended to provide care to all enrolled CMHC-HH recipients.	Electronic Claims Data	**Numerator** = the accumulated Medicaid expenditures (inpatient, outpatient, pharmacy, ancillary services) associated with all enrolled CMHC-HH recipients **Denominator** = total	DSS will utilize its electronic claims system to identify total costs associated with CMHC-HH recipients.	Comprehensive Care Management	NCQA

			number of enrolled CMHC-HH recipients.			
	Accessing appropriate levels of care: The CMHC-HH provides education on appropriate ER utilization and DSS tracks overall ER utilization to measure reductions over a 12-month period.	Electronic Claims Data	**Numerator** = Number of annual CMHC-HH emergency room visits **Denominator** = total CMHC-HH member months x 12 x 1,000.	DSS will utilize its electronic claims system to measure emergency room visits/1000 members/year.	Comprehensive Care Management	NCQA
	Utilization Management Performance: The practice manages the BH - HH recipient population for those 75 years of age and under . to reduce the overall hospitalizations over a 12 month period. DSS measures admits per thousand annually.	Electronic Claims Data	**Numerator** = For a 12 month period, utilizing the HEDIS 2011 codes for inpatient general hospital/acute care, inpatient alcohol and other drug services and inpatient mental health services discharges calculate the total number of hospital bed days for al HH recipients under age 75 **Denominator** = the average number of CMHC-HH recipients under age 75 during that same time period x 1,000.	DSS will utilize its electronic claims system to measure hospital bed days and its enrollment system to measure the average number of CMHC-HH recipients to calculate admits per thousand.	Comprehensive Care Management	HFMA (Healthcare Financial Management)
	Utilization Management Performance: The practice manages the BH - HH recipient population to reduce hospital readmissions for the same or similar diagnosis within a 30 day period over a 12 month period.	Electronic Claims Data	**Numerator** = the number of CMHC-HH recipients admitted to a hospital for the same or similar diagnosis within 30 days of a hospital discharge **Denominator** = the total number of hospital discharges during the	DSS will utilize its electronic claims system to identify hospital readmissions for the same or similar diagnosis within 30 days of a hospital discharge to measure readmission rates	Comprehensive Care Management	CMS

			same reporting period.	over a 12 month period.		
	Utilization Management Performance: The practice manages the BH - HH recipient population 18 years of age and older to reduce hospital readmissions for the same or similar diagnosis within a 30 day period over a 12 month period.	Electronic Claims Data	**Numerator** = the number of CMHC-HH recipients 18 years of age or older admitted to a hospital for the same or similar diagnosis within 30days of a hospital discharge **Denominator** = the total number of hospital discharges of CMHC-HH recipients 18 years of age or older during the same reporting period.	DSS will utilize its electronic claims system to identify hospital readmissions for the same or similar diagnosis within 30 days of a hospital discharge to measure readmission rates over a 12 month period.	Comprehensive Care Management	CMS
	Track & Coordinate Care: The practice tracks referrals using a reporting log or electronic reporting system. The tracked referrals are those determined by the clinician to be important for a BH - HH recipient's treatment or as indicated by practice guidelines.	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients referred by a clinician **Denominator** = all active CMHC-HH recipients during the same reporting period.	The CMHC-HH tracks identified referral through its electronic health record or practice management system. Results will be submitted in flat file to the state by individual recipient.	Care Coordination	NCQA
	Care Transition: Transition Record Transmitted to CMHC-HH The practice tracks the percentage of patients, regardless of age, discharged from an inpatient facility to home or any of other site of care for whom a transition record was transmitted to the facility or designated health professional for follow-up care within 24 hours of discharge.	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients with a transition record from an inpatient facility (hospital inpatient or observation, skilled nursing facility or rehabilitation facility) transmitted to the CMHC-HH for follow-up care within 24 hours of discharge.	The CMHC-HH tracks follow-up care delivered within 24 hours of discharge through its electronic health record or practice management system. Results will be submitted in flat file to the	Comprehensive Care Management	NCQA

			Denominator = All CMHC-HH recipients discharges from an inpatient facility (hospital inpatient or observation, skilled nursing facility or rehabilitation facility) to home/self-care or any other site of care.	state by individual recipient.		
	Follow-up After Hospitalization for Mental Illness: BH HH tracks the percentage of HH recipients 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.	Recipient Electronic Health Record	**Numerator** = An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to table FUH-C in the original measure documentation codes to identify visits) with a mental health practitioner within 7 days after discharge.. Include outpatient visits, an intensive outpatient encounters, or partial hospitalizations that occur on the day of discharge. **Denominator =** Recipients 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December	The CMHC-HH tracks follow-up care delivered within 24 hours of discharge through its electronic health record or practice management system. Results will be submitted in flat file to the state by individual recipient.	Comprehensive Care Management	NCQA

			31 of the measurement year.			
Goal 3: Transform the primary care health care delivery system.	**Measures**	**Data Source**	**Measure Specification**	**How HIT will be Utilized**		Measure Steward
Clinical Outcomes	N/A					
Experience of Care	**Self-Management**: Recipient & Family Support: Provide educational resources or refers at least 50% of CMHC-HH recipients/families to educational resources to assist in self-management.	Recipient Electronic Health Record	**Numerator** = the number of CMHC-HH recipients that were provided educational resources or referrals **Denominator** = all active CMHC-HH recipients during the same time period. Educational materials or referrals provided are to be documented in CMHC-HH recipients electronic health record	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Patient & Family Support	NCQA
	Self-Management: Counsel at least 50% of CMHC-HH recipients/families to adopt healthy behaviors associated with disease risk factors (tobacco use, nutrition, exercise & activity level, alcohol	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients that have been educated on health risks associated with disease risk factors.	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual	Patient & Family Support	NCQA

	use).		**Denominator** = Total number of active CMHC-HH recipients during the reporting period.	recipient.		
	Plan & Manage Care: Conduct pre-visit preparations and collaborate with CMHC-HH patient/family to develop an individual care plan that includes treatment goals. .	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients whose medication, laboratory, and radiology orders created by provider are recorded using CPOE/EHR. **Denominator** = Total number of active CMHC-HH recipients during the reporting period.	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Health Promotion & Chronic Care Management	NCQA
	Plan & Manage Care: Provide the CMHC-HH recipient/family a clinical summary of each relevant visit	Recipient Electronic Health Record	**Numerator** = Number of CMHC-HH recipients that had a visit during the reporting period **Denominator** = all active CMHC-HH recipients during the same time period.	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Health Promotion & Chronic Care Management	NCQA
Quality of Care	**Comprehensive Care**: The practice follows up with BH - HH recipients who have not kept important appointments, such as for rechecks, preventive care, or post hospitalization.	Recipient Electronic Health Record/Practice Records	**Numerator** = Number of missed CMHC-HH recipients appointments **Denominator** = Number of scheduled CMHC-HH recipient visits in the reporting period.	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Comprehensive Transitional Care & Follow-up	NCQA
	Plan and Manage Care: Identify CMHC-HH recipients/families who might benefit from additional care management support.	Recipient Electronic Health Record /Practice Records	**Numerator** = Number of recipients identified and referred for additional support services	Utilizing the HH's electronic health record, results will be submitted in	Comprehensive Transitional Care & Follow-up	NCQA

			Denominator = all active CMHC-HH recipients during the same time period.	flat file to the state by individual recipient.		
	Self-Management: Document self-management abilities for at least 50% of CMHC-HH patients/families.	Recipient Electronic Health Record /Practice Records	**Numerator** = Number of CMHC-HH recipients with self-management abilities documented in recipient health record **Denominator** = all active CMHC-HH recipients during the same time period.	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Patient & Family Support	NCQA
	Self-Management: Provide self-management tools to enable BH - HH recipients to record self care results for at least 50% of CMHC-HH patients/families.	Recipient Electronic Health Record /Practice Tools	**Numerator** = Number of CMHC-HH recipients utilizing self-management tools to record self care results **Denominator** = all active CMHC-HH recipients during the same time period.	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Patient & Family Support	NCQA
	Track & Coordinate Care: Demonstrate the capability for electronic exchange key clinical information	CMHC-HH Attestation	CMHC-HH attests that their CMHC-HH electronic Health Record has been functional for a twelve month period	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Care Coordination	NCQA
	Track & Coordinate Care: Provide an electronic summary of care record for more than 50% of referrals to the referred specialists.	Recipient Electronic Health Record	**Numerator** = Number of times CMHC-HH recipient information was transferred (recipients electronic health record indicates a specialty referral) in a 90 day period	Utilizing the HH's electronic health record, results will be submitted in flat file to the state by individual recipient.	Health Promotion & Chronic Care Management	NCQA

			Denominator = number of CMHC-HH recipients actively enrolled in the BH-H at any point during the 90 days x 90.			